

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER Los Palos Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1430 West 6th Street San Pedro, CA 90732	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report a COVID - 19 (a potentially severe illness caused by a coronavirus and characterized by fever, cough, and shortness of breath) outbreak to the California Department of Public Health (CDPH) when three residents (Residents 6, 7, and 8) tested positive for COVID-19 indicative of a facility outbreak. Findings: a. During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including arthrogryposis multiplex congenita (a rare, non-progressive condition present at birth, characterized by multiple, stiff, contracted joints (contractures) and muscle weakness). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 7/7/2025, the MDS indicated Resident 6's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required substantial/maximal assistance (helper does more than half the effort) from staff to complete her activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 6's COVID- 19 Antigen test result (examines bodily fluids for specific markers of a disease) dated 9/15/2025, the test result indicated Resident 6 tested positive for COVID-19 on 9/15/2025. b. During a review of Resident 7's admission Record (Face Sheet), the Face Sheet indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognition was moderately impaired required partial/moderate assistance (helper does less than half the effort) from staff to complete her ADLs. During a review of Resident 7's COVID- 19 Antigen test result dated 9/15/2025, the test result indicated Resident 7 tested positive for COVID-19 on 9/15/2025. c. During a review of Resident 8's admission Record (Face Sheet), the Face Sheet indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including DM. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8's cognition was moderately impaired and required partial/moderate assistance from staff to complete her ADLs. During a review of Resident 8's COVID- 19 Antigen testing results dated 9/15/2025, the testing results indicated Resident 8 tested positive for COVID-19 on 9/15/2025. During an interview on 9/19/2025 at 11:58 a.m., with the Infection Prevention Nurse (IP), the IP Nurse stated she reported the outbreak to the local health department after the residents tested positive on 9/15/2025 but did not report the outbreak to CDPH. During an interview on 9/20/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated an outbreak of COVID-19 should be reported to CDPH to ensure proper measures are being done to prevent the virus from spreading within and outside the facility. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, dated 12/2007, the P&P indicated as required by federal or state regulations, the facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees, or visitors. The P&P indicated the facility will report the following events to appropriate agencies including an outbreak of any communicable disease.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
-----------------------------------------------------------------------	-------	-----------